Chapter 4: Enhancing Access to Health Care Services

Clear and Compelling Purpose: Outpatient Access and Inpatient Capacity

The growth of Community-Based Outpatient Clinics (CBOCs) has improved access to services for veterans. CARES provided a mechanism to measure progress towards its stated goal of "improving quality as measured by access."[1] Complementary to this stated goal was the intention to ensure that the current and future acute care infrastructure is capable of meeting the needs of veterans who access health care services. The CARES process enabled VA to develop a cost effective investment strategy to improve access in selected markets and ensure the availability of the acute care infrastructure.

Measuring Veteran Access to Care

The traditional way of measuring access in VHA was through determining where patients from a given county seek specific types of treatment, such as primary care, inpatient acute care, mental health care and specialized services. Episodes of treatment at all VA facilities in that county were tallied over a three-year period, and the proportional use of each VA facility was determined, i.e., which percent used facility "A" vs. facility "B," etc. Travel time to obtain services was not measured.

As previously noted, the planning focus of the CARES process was the "market," or a distinct veteran population in a defined geographic area. The state-of-the-art methodology used in CARES not only was capable of greater precision in measuring access, but also provided more information to support planning decisions. The CARES approach involved determining the percentage of enrollees living within specific travel times to the nearest, appropriate VHA facility.

The new data allowed access within each market to be scored with regard to two "thresholds:" first, a minimum *percentage* of enrollees living *within* a specified travel time to obtain VA primary care; second, notwithstanding the percentage of enrollees living within these travel times, the total *number* living *outside* the guidelines could not exceed a specified number. In other words, to qualify as an "access" planning initiative according to the criteria developed for CARES, a market had to first meet a *relative* standard (percentage living within access guidelines) as well as an *absolute* standard (a specified number of enrollees living outside access guidelines). Table 4.1 presents the specific criteria.

[1] VHA Directive 2002-032, June 5, 2002; "Capital Asset Realignment for Enhanced Services (CARES) Program"

Table 4.1 Access Criteria

Type of Care	Time Criteria (Minutes)	Threshold Criteria (%)	Number of Enrollees Outside Guidelines	# of PIs
Primary Care	30 Min. – Urban 30 Min. - Rural 60 Min. - Highly Rural	70%	Less Than 11,000	27
Acute Hospital	60 Min. - Urban 90 Min. - Rural 120 Min. - Highly Rural	65%	Less Than 12,000	24
Tertiary Care	240 Min. - Urban 240 Min. - Rural Community Standard – Highly Rural	65%	Less Than 12,000	6

(Specific methodology for calculating travel time to VA care can be found in Appendix P; a technical explanation of specific access calculations is contained in the References Section.)

To illustrate the application of these criteria as shown in Table 4.1 above, the first line in the table (dealing with primary care) should be understood to connote the following:

- Column 1: states type of care as Primary, Acute Hospital or Tertiary.
- Column 2 (time criteria) and Column 3 (threshold): taken together, stipulate that at least 70 percent of enrolled veterans living in urban or rural areas of the market should live within the following travel times to a VA primary care facility: for urban and rural areas, 30 minutes; for highly rural areas, 60 minutes.
- Column 4 (number of enrollees): states that there can be no more than specified number of enrollees living outside the time guidelines.
- Column 5 (number of PI's): reports that 27 planning initiatives were proposed to correct "access issues" nationwide for primary care.

An "access issue" was defined in markets that failed to meet both thresholds, i.e., less than the stated percentage of enrollees met the travel time requirement *and* more than the specified number of enrollees lived outside the travel time guidelines. Following the data analysis and identification of access issues, VA planners developed solutions within each market, for each Access Planning Initiative.

Of the 57 total Access Planning Initiatives, 27 (or 47%) were for primary care, 24 (or 42%) for acute hospital care, and six (or 11%) for tertiary hospital care. (Appendix D contains a listing of access initiatives for each VISN.)

Summary of Access Planning Initiative Solutions
Approaches to resolving access issues fell into the following categories:

Primary Care
- New community-based outpatient sites, either VA-staffed (i.e., "in-house") or via contract
- New Joint VA/DoD ambulatory care clinics

Acute Hospital Care
- Renovation of existing infrastructure to reactivate acute care services
- Referral to other VA facilities that may have augmented capacity
- Contracting with, or leasing space within, community-based non-VA facilities
- Joint ventures or sharing agreements with DoD or affiliated hospitals

Tertiary Care Services
- Contracting with community tertiary care facilities and DoD facilities
- Referrals to VA tertiary facilities that may have augmented capacity

Outpatient Access Investment Strategy
The backlog of acute inpatient capital needs identified in the CARES process has made the improvement of access a complex problem from many perspectives. Increases in new access points historically have generated new users to the VHA health care system beyond forecasted utilization. This new demand for care, if not cautiously approached in the National CARES Plan, could increase acute inpatient needs before a systematic infrastructure improvement process is in place to ensure that the expected new demand can be met in a quality inpatient environment. In addition, the financial requirements for construction or leases of new access sites, as well as for additional operating funds, would compete with the funding requirements for delivering health care services to current and projected veteran enrollees.

An important initial step for CARES was to produce a system-wide assessment of the magnitude of capital and operating needs. The magnitude of the capital backlog, the growth in projected outpatient demand, and the number of access gaps had not been systematically measured prior to the CARES process. In the CARES effort, VISNs proposed to meet these projected increases in outpatient demand through renovation and expansion of existing outpatient delivery sites, and through establishing 161 new CBOCs in markets where there were Access Planning Initiatives. In addition, 73 new CBOCs were proposed in markets where there was *not* an Access Planning Initiative, but where there were gaps between future projected demand and current capacity.

When the results of the market plans were compiled, it was clear that difficult policy decisions had to be made in order to achieve a balanced growth of outpatient capacity and access, while ensuring the safety and availability of the acute inpatient infrastructure. As a result, the National CARES Plan includes CBOC priority groups that focused the initial growth of CBOCs in markets with large future outpatient gaps (Capacity Planning Initiatives), large access gaps (Access Planning Initiatives) and

where the largest number of projected enrollees per new CBOC reflects an efficient allocation of resources.

The following are the priority groups that comprise the CBOC investment strategy in the National CARES Plan:

- Highest priority group (1):
  Markets that have large future capacity gaps in addition to large access gaps and where the number of enrollees who do not meet access guidelines per CBOC proposed is greater than 7,000 enrollees per CBOC (48 CBOCs). This group includes additional CBOCs that are linked to realignment and five key DoD outpatient collaborations.

- Second priority group (2):
  Markets that met the same criteria as in highest priority group, but where the numbers of enrollees that do not meet access guidelines are less than 7,000 enrollees per CBOC proposed.

- Third priority group (3):
  Markets with large demand gaps but where 70% or more enrollees were within access driving time guidelines. Since these markets did not have access planning initiatives a planning target for them is to meet their growth in outpatient demand by expansion at existing sites.

Inpatient Access Investment Strategy
Improvements in inpatient access were considered more critical than improvements in outpatient access, since an acute inpatient episode of care presents a daily burden to a veteran's support system. Many studies have described the importance of that support system in reducing lengths of stay and improving clinical outcomes. VISN Market Plans often proposed the use of contract care to improve hospital access, a solution that can be more flexible in covering the geography of a market, meeting fluctuations in demand and as a result may be more cost effective than the establishment of VA-owned sites of care. Improving inpatient access while meeting future capacity requirements can be accomplished without creating the kind of competing resource demands noted in the outpatient care situation.

Projected Improvements In Access
Tables 4.2 and Table 4.3 show the improvement in the enrollee population access to care. Table 4.2 contains information on the projected improvements in access percentages and the number of enrollees remaining outside the access guidelines by type at the national level. The primary care access data only includes the impact of the 48 CBOCs in the high priority group. It is important to compare these numbers with the baseline acceptable level, or threshold, which was 70% of enrollees within travel time guidelines for primary care, 65% for hospital and tertiary care.

Table 4.2 Percent Enrollees Within Guidelines and Number of Enrollees Outside Guidelines By Type: FY 2001 – FY 2022

Type	FY 2001		FY 2012		FY 2022	
	Percent Enrollees Within Guideline	Number Enrollees Outside Guidelines	Percent Enrollees Within Guideline	Number Enrollees Outside Guidelines	Percent Enrollees Within Guideline	Number Enrollees Outside Guidelines
Primary Care	74%	1,474,354	74%	1,554,720	74%	1,410,224
Hospital Care	72%	1,573,205	82%	1,079,649	82%	970,448
Tertiary Care	94%	318,960	97%	179,941	97%	161,741

(Compare with baseline thresholds of 70% for primary care, 65% for hospital and tertiary care.)

As indicated in Table 4.2, from a national system perspective, most VA medical facilities are currently within national guidelines for access, since most facilities are located near veteran population centers and because of the growth in the VA of over 600 CBOCs. Current high levels of access are consistent with an investment strategy that ensures the availability of the acute care infrastructure to veterans.

With the implementation of the National CARES Plan, dramatic improvement is projected in acute hospital care access (approximately 600,000 more enrollees within guidelines) and significant improvement is projected in tertiary care access (approximately 150,000 more enrollees within guidelines). While the number of enrollees outside primary care access guidelines increases in FY 2012, it drops slightly below the FY 2001 baseline in FY 2022. The increase in the number of enrollees outside access guidelines in FY 2012 is due to the peak in total enrollment during that time period, although the percentage of total enrollees within access guidelines remains steady at 74 percent.

If the 48 new high priority group CBOCs (in eight additional market areas) were implemented, then, by FY 2012, 79% of all markets (see Table 4.3) would be projected to have achieved the threshold for primary care access. Substantial improvements in hospital access occur as well. Projecting forward to FY 2022, the forecast was that these access improvements would be sustained for primary and tertiary care, and there would be a slight additional improvement for hospital care.

Table 4.3 Percentage of Market Areas within Access Guidelines By Type: FY 2001 – FY 2022 (73 Market Areas – excludes Puerto Rico)

Type	FY01	FY12	FY22
Primary Care	67%	79%	79%
Hospital Care	66%	89%	90%
Tertiary Care	100%	100%	100%

New Primary Care Access Sites

Table 4.4 lists the specific CBOCs included in the highest priority CBOC investment group. These 48 CBOCs are located in markets that have large future capacity gaps in

addition to large access gaps and where the number of enrollees who do not meet access guidelines per CBOC proposed is greater than 7,000 enrollees per CBOC. In addition to this list of 48 CBOCs, new primary care access sites that are linked to realignment or key DoD collaborations are also considered in the highest priority CBOC investment group.

Table 4.4 New Access Sites in National CARES Plan

VISN	Market Area	Facility Parent	Facility Name	Planned to Oper
6	Northeast	Richmond	Charlottesville	2006
6	Northeast	Richmond	Emporia	2005
6	Northeast	Hampton	Norfolk	2005
6	Southwest	Asheville	Franklin	2004
6	Southwest	Salisbury	Greensboro	2007
6	Southwest	Asheville	Hendersonville	2004
6	Southwest	Salisbury	Hickory	2004
6	Southwest	Salisbury	Gastonia	2010
6	Southwest	Asheville	Rutherfordton	2009
7	Alabama	Birmingham	Opelika	2009
7	Alabama	Birmingham	Childersburg	2006
7	Alabama	Birmingham	Guntersville	2008
7	Alabama	Birmingham	Bessemer	2004
7	Alabama	CAVHCS - West Campus	Enterprise	2010
7	Georgia	Augusta	Aiken	2006
7	Georgia	Augusta	Athens	2004
7	Georgia	Dublin	Milledgeville	2009
7	Georgia	Dublin	Brunswick	2008
7	Georgia	Atlanta	Stockbridge	2007
7	Georgia	Atlanta	Newnan	2008
7	Georgia	Dublin	Perry	2005
7	South Carolina	Charleston	Hinesville	2006
7	South Carolina	Columbia (SC)	Spartanburg	2005
7	South Carolina	Charleston	Summerville	2006
8	North	Gainesville	Camden	2006
8	North	Gainesville	Jackson County	2005
8	North	Gainesville	Putnam	2005
8	North	Gainesville	Summerfield	2006
16	Central Lower	Houston	Conroe	2005
16	Central Lower	Alexandria	Fort Polk	2005
16	Central Lower	Houston	Galveston (Dual Site-Site 1)	2004
16	Central Lower	Houston	Galveston (Dual Site-Site 2)	2004
16	Central Lower	Houston	Katy	2007
16	Central Lower	Alexandria	Lake Charles	2006
16	Central Lower	Houston	Lake Jackson	2009

VISN	Market Area	Facility Parent	Facility Name	Planned to Open
16	Central Lower	Alexandria	Natchitoches	2006
16	Central Lower	Houston	Richmond	2008
16	Central Lower	Houston	Tomball	2006
16	Eastern Southern	Eastern Southern	Eglin AFB	2004
20	Inland North	Spokane	Central Washington	2006
23	Iowa	Des Moines	Carroll	2006
23	Iowa	Des Moines	Marshalltown	2004
23	Iowa	Iowa City	New Cedar Rapids	2004
23	Iowa	Iowa City	Ottumwa	2006
23	Minnesota	St. Cloud	Alexandria	2005
23	Minnesota	Minneapolis	Elk River	2005
23	Minnesota	Minneapolis	Redwood Falls	2006
23	Minnesota	Minneapolis	Rice Lake	2007